Payment to Agency Report

1. Agency Name
   Department of Health Care Services
   Administration Division, Human Resources Branch
   P.O. Box 997411, MS 1300

   Area Code/Phone Number
   (916) 552-8270
   Email
   ConflictOfInterest@dhcs.ca.gov
   Agency Contact
   Conflict of Interest Filing Officer

2. Donor Name and Address

   National Association of Medicaid Directors
   444 North Capitol Street, Suite 524
   Washington, DC 20001

   NAMD's sole function is to represent & support the Medicaid Directors in 56 states, territories & the District of Columbia

   If "Other" is marked, describe the entity's business activity (if business) or its nature and interests.

   If applicable, identify the name of each source and the amount(s) received by the donor for this payment:

<table>
<thead>
<tr>
<th>Name</th>
<th>Amount</th>
<th>Name</th>
<th>Amount</th>
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</thead>
</table>

3. Payment Information (Complete Sections 3.1 (a or b), 3.2, 3.3)

3.1 (a) Travel Payment
   Location of Travel
   Snowbird, UT
   Dates (month, day, year)
   06/09/2019-06/11/2019

   Transportation Provider
   Southwest Airlines
   □ Rail  □ Air  □ Bus  □ Auto  □ Other
   Check Applicable Boxes

   $357.16 Lodging Expenses
   $45.00 Meal Expenses
   $352.45 Transportation Expenses
   $10.00 Other Expenses
   $764.61 Total Expenses

3.1 (b) Payment(s) not related to travel:

3.2. Payment Description. Provide a specific description of the payment and its agency purpose and use.

   Travel to attend 2019 NAMD Spring Membership meeting in Snowbird, UT.

3.3. Identify the officials who used the payment in Section 3.1 (See instructions)

   Cooper
   Jacey

   Senior Advisor
   N/A

   DHCS/Health Care Program
   N/A

4. Verification

   I authorized the acceptance of the reported payment(s) as in compliance with FPPC regulations.

   Erika Sperbeck
   Chief Deputy Director

   7/19/19

   Comment:
   (Use this space or an attachment for any additional information)
Payment to Agency Report

1. Agency Name
   Department of Health Care Services
   Administration Division, Human Resources Branch
   P.O. Box 997411, MS 1300

2. Donor Name and Address
   National Association of Medicaid Directors
   444 North Capitol Street, Suite 524
   Washington, DC 20001
   LDAP's sole function is to represent & support the Medicaid Directors in 56 states, territories & the District of Columbia

3. Payment Information (Complete Sections 3.1 (a or b), 3.2, 3.3)

   3.1 (a) Travel Payment
   Location of Travel: Snowbird, UT
   Dates (month, day, year): 06/09/2019-06/11/2019
   Southwest Airlines
   Transportation Provider
   □ Rail □ Air □ Bus □ Auto □ Other
   Check Applicable Boxes
   □ Lodging Expenses □ Meal Expenses □ Transportation Expenses □ Other Expenses
   □ Total Expenses
   $357.16   $45.00   $352.00   $10.00   $764.16

   3.1 (b) Payment(s) not related to travel:
   Dates (month, day, year): $ Total Expenses

   3.2. Payment Description. Provide a specific description of the payment and its agency purpose and use.
   Travel to attend 2019 NAMD Spring Membership meeting in Snowbird, UT.

   3.3. Identify the officials who used the payment in Section 3.1 (See instructions)
   Ducay
   Last Name: N/A
   First Name: N/A
   Assistant Deputy Director
   Last Name: N/A
   First Name: N/A
   DHCS/Health Care Financin
   Last Name: N/A
   First Name: N/A

4. Verification
   Authorized the acceptance of the reported payment(s) as in compliance with FPPC regulations.
   Erika Sperbeck
   Signature
   Print Name
   Chief Deputy Director
   Title
   (month, day, year)

Comment:
(Use this space or an attachment for any additional information)
FPSC Form 801 (Jan/14)
advice@fpcc.ca.gov
Payment to Agency Report

1. Agency Name
   Department of Health Care Services
   Administration Division, Human Resources Branch
   P.O. Box 997411, MS 1300
   Area Code/Phone Number: (916) 552-8270
   Email: ConflictOfInterest@dhcs.ca.gov
   Agency Contact (name and title): Conflict of Interest Filing Officer

2. Donor Name and Address
   □ Individual  □ Other  National Association of Medicaid Directors
   444 Capitol Avenue, Suite 524  Washington  DC  20001
   Address  City  State  Zip Code
   NAMD's sole function is to represent & support the Medicaid Directors in 56 states, territories & the District of Columbia.
   If "Other" is marked, describe the entity's business activity (if business) or its nature and interests.
   → If applicable, identify the name of each source and the amount(s) received by the donor for this payment:
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3. Payment Information (Complete Sections 3.1 (a or b), 3.2, 3.3)

3.1 (a) Travel Payment
   Snowbird, Utah
   Location of Travel
   Transportation Provider:
   □ Rail  □ Air  □ Bus  □ Auto  □ Other
   Check Applicable Boxes
   Lodging Expenses: $357.16  Meal Expenses: $45.00  Transportation Expenses: $344.93  Other Expenses: $10.00
   Total Expenses: $757.09
   Dates (month, day, year):
   June 9-11, 2019

3.1 (b) Payment(s) not related to travel:
   Dates (month, day, year):
   Total Expenses:
   $              

3.2. Payment Description. Provide a specific description of the payment and its agency purpose and use.
   To attend the NAMD 2019 Spring Membership Meeting in Snowbird, Utah.

3.3. Identify the officials who used the payment in Section 3.1 (See instructions)
   Cantwell  Marianne  Chief Deputy Director  Health Care Programs
   Last Name  First Name  Position/Title  Department/Division
   Last Name  First Name  Position/Title  Department/Division

4. Verification
   Authorized the acceptance of the reported payment(s) as in compliance with FPPC regulations.
   Erika Sperbeck  Chief Deputy Director
   Print Name  Title
   Date (month, day, year):
   7. 19. 19

Comment:
(Use this space or an attachment for any additional information)